Protector Rider

The Protector Rider can only be bought along with the Base Plan and cannot be bought in isolation or as a separate product. The Rider is subject to the terms and conditions stated below and also the Policy terms, conditions, exclusions and applicable endorsements of the Base Plan. This Rider shall be available only if the same is specifically mentioned in the Policy Schedule.

Section 1. Benefits

Please Note: Any claim under any of the benefits mentioned in this rider Policy will only be admissible when it qualifies according to the terms, conditions and exclusions in the Base Plan.

A. Claim Protector

If a claim has been accepted under the Base plan, then the items which are not payable under the Base Plan as per the List of Excluded items released by IRDA (Refer Annexure 1) related to the particular claim will become payable. The maximum claim payout under this benefit shall be limited to Base Sum Insured under Base Plan.

B. Multiplier Benefit/Cumulative Bonus Protector

Multiplier Benefit/Cumulative Bonus will not be impacted or reduced at renewals if any one claim or multiple claims admissible in the previous policy year under the Base Plan does not exceed the overall amount of Rs. 50,000.

Illustration:
Consider an Insured Person is having a Base plan of Rs.5 Lakhs and along with Base plan he/she purchases this rider.

Policy Year	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
Basic Sum Insured (in Rs.)	500,000	500,000	500,000	500,000	500,000	500,000
Claims Status (Yes, No)	No	No	Yes	No	Yes	No
Total admissible Claim amount under the Base Plan (in Rs.)	NA	NA	48,000	NA	56,000	NA
- Payable claim amount (in Rs.)	NA	NA	40,000	NA	47,000	NA
- Claim amount attributed to Non Payable items as per List of Excluded items released by IRDA (in Rs.)	NA	NA	8,000	NA	9,000	NA
Impact on Multiplier Benefit/Cumulative Bonus			No (Total admissible claim amount under the Base plan is less than Rs. 50,000)		Yes (Total admissible claim amount under the Base plan is more than Rs. 50,000)	
Multiplier Benefit/Cumulative Bonus (in Rs.) (consider, Multiplier Benefit/Cumulative Bonus of 50% of the Basic Sum Insured for every claim free year, maximum up to 100%)	NA	250,000	500,000	500,000	500,000	250,000
Total Amount (in Rs., at beginning of the year)	500,000	750,000	1,000,000	1,000,000	1,000,000	750,000

C. Sum Insured Protector

The Sum Insured protector is designed to protect Your Sum Insured against rising inflation by linking the Basic Sum Insured under the Base Plan to the Consumer Price index (CPI).

The Basic Sum Insured will be increased on cumulative basis at each renewal on the basis of inflation rate in previous year. Inflation rate would be computed as the average CPI of the entire calendar year published by the Central Statistical Organisation (CSO).
The % increase will be applicable only on Basic Sum Insured under the Policy and not on Multiplier Benefit/Cumulative Bonus or any other benefit which leads to increase in Sum Insured.

What is Consumer Price Index (CPI)?
CPI is a measure of inflation, changes in the CPI are used to assess price changes associated with the cost of living. It is a measure that examines the weighted average of prices of a basket of consumer goods and services, such as transportation, food and medical care. It is calculated by taking price changes for each item in the predetermined basket of goods and averaging them.

The Central Statistics Office (CSO) is a government agency in India under the Ministry of Statistics and Programme Implementation responsible for co-ordination of statistical activities in India, and evolving and maintaining statistical standards.

Illustration:

Consider an Insured Person is having a Base plan of Rs.5 Lakhs and along with Base plan he/she purchases this rider.

Policy Year	**Year 1**	**Year 2**	**Year 3**	**Year 4**
Basic Sum Insured (in Rs.)	500,000	500,000	500,000	500,000
CPI Linked inflation Rate (%)	6%	5%	5%	-
Total Sum Insured (in Rs., at beginning of the year)	500,000	530,000 (6% X 500,000)	556,500 (5% X 530,000)	584,325 (5% X 556,500)

In case of Sum Insured enhancement or reduction at the time of renewal, any accumulated sum Insured due to Sum Insured Protector Benefit will be added to the enhanced or reduced Sum Insured opted by Insured at the time of renewal.

Referring to above illustration,

	Consider Insured opts to increase the Sum Insured to Rs. 10 Lakhs at the time of renewal in Year 4	Consider Insured opts to decrease the Sum Insured to Rs. 3 Lakhs at the time of renewal in Year 4
Basic Sum insured (in Rs.)	1,000,000	300,000
Accumulated Sum Insured Protector Benefit (in Rs.)	84,325 (584,325 – 500,000)	84,325 (584,325 – 500,000)
Total Sum Insured (in Rs., at beginning of Year 5)	1,084,325	384,325

*Accumulated Sum Insured Protector Benefit = Total Sum Insured at beginning of Year 4 - Total Sum Insured at beginning of Year 1

Please Note that all the accumulated Sum Insured Protector benefit will lapse and your Sum Insured under Base Plan will roll back to the Basic Sum Insured opted under the Base Plan if this rider Policy is not renewed.

Section 2. General Exclusions

All exclusions as mentioned in the Base Plan unless otherwise stated and covered in Section 1 of Protector Rider policy wordings.

Section 3. Terms & Conditions applicable in the Policy

A. **Policy Period**
The policy will be issued for a period of 1, 2 & 3 year(s) period depending on the period of Base Plan.

B. **Loading**
Premium of this Policy is dependent on premium of Base Plan. In case a risk loading is applied on Base Policy leading to increase in premium of Base Plan, premium of this rider Policy will be increased in commensuration with premium of Base Plan.

C. **Discount**
i. Discount of 7.5% on 2 years and 10% on 3years policy premiums when paid on lump sum payment mode.

ii. Family Discount of 10% if 2 or more family members are covered under Individual Sum Insured Plan of this Policy.

D. **Waiting Period**

There are no waiting periods in this Policy. However, this Policy shall follow waiting periods applicable in Base Plan.

E. **Premium Payment in Instalments**

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period of 15 days would be given to pay the instalment premium due for the policy.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the grace period, the policy will get cancelled.

vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

However, premium payment mode under this rider Policy will be same as that of premium payment mode chosen in Base Plan or it can be lump sum payment.

i.

F. **Cancellation**

i. The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

i.

1 Year Policy Period		**2 Year Policy Period**		**3 Year Policy Period**	
Length of time Policy in force	**% of premium refunded**	**Length of time Policy in force**	**% of premium refunded**	**Length of time Policy in force**	**% of premium refunded**
Up to 1 Month	75.00%	Up to 1 Month	87.50%	Up to 1 Month	91.70%
Up to 3 Months	50.00%	Up to 3 Months	75.00%	Up to 3 Months	83.30%
Up to 6 Months	25.00%	Up to 6 Months	62.50%	Up to 6 Months	75.00%
Exceeding 6 Months	Nil	Up to 12 Months	48.00%	Up to 12 Months	66.60%
		Up to 15 Months	25.00%	Up to 15 Months	50.00%
		Up to 18 Months	12.00%	Up to 18 Months	41.60%
		Exceeding 18 Months	Nil	Up to 21 Months	33.30%
				Up to 24 Months	8.30 %
				Exceeding 24 Months	Nil

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

iii.

Non- Disclosure or Misrepresentation:

I. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

i. cancelled ab initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, at our sole discretion, upon 15 day notice by sending an endorsement to Your address shown in the Schedule; and

ii. the claim under such Policy if any, shall be prejudiced.

II. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/Misrepresentation of Pre-existing diseases subject to your prior consent;

i. Permanently exclude the disease/condition and continue with the Policy

ii. Incorporate additional waiting period of not exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.

iii. Levy underwriting loading from the first year of issuance of policy or renewal, whichever is later.

The above options will not prejudice the rights of the Company to invoke cancellation under clause I above.

- **Fraud :**

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

G. **Free Look Period**

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

H. **Renewal of Policy**

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience.
vi. This Policy will be renewed only if Base Plan is being renewed. In case Base Plan is not being renewed, this rider Policy will not be eligible to be renewed.

I. **Notification of Claims**

We must be informed of any event or occurrence that may give rise to a claim under this Policy within 30 days of it occurrence.

J. **Claim Payment - Important terms and conditions**

i. Claim under this rider Policy will only be admissible when it qualifies according to the terms, conditions and exclusions in the Base Plan.
ii. We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realized and We have been provided with the documentation and information We have requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.
iii. We will only make payment to You under this Policy. Receipt of payment by You shall be considered as a complete discharge of Our liability against the respective claim under this Policy. In the event of Your death, We will make payment to the Nominee (as named in the Policy Schedule), payments under this Policy shall only be made in Indian Rupees within India.
iv. The assignment of benefits of the policy shall be subject to applicable law.
v. We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person had not taken undue risk.
vi. Claim Settlement (Provision for Penal Interest):
    a. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

    b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

    c. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

d. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

vii.

- **Claims Payment for instalment payments**

  Please note that following conditions will be applied for monthly, Quarterly and Half-yearly premium payment options:

  i. In case of any Hospitalization claim, an amount equivalent to the balance of the instalment premiums payable in the Policy Year, would be recoverable from the admissible claim amount payable in respect of the Insured Person. This provision will not apply to claims arising under Preventive Health Check-up.

  ii. If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered. This provision will not apply to claims arising under Preventive Health Check-up.

K. **Notices**

Any notice, direction or instruction under this Policy shall be in writing and if it is to:

i. Any Insured Person, it would be sent to You at the address specified in Schedule / endorsement.
ii. Us, shall be delivered to Our address specified in the Schedule.
iii. No insurance agents, brokers, other person/ entity is authorised to receive any notice on Our behalf.

L. **Moratorium Period**

After completion of eight continuous years under this **Policy** no look back would be applied. This period of eight years is called as Moratorium Period. The moratorium would be applicable for the Sums Insured of the first Policy and subsequently completion of eight continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this Policy shall be contestable except for proven fraud & permanent exclusions specified in the policy contract. The Policy would however be subject to all limits, sub limits, co-payments, Deductibles as per the policy contract.

M. **Dispute Resolution Clause**

Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law.

N. **All other conditions will be applicable as mentioned in the Base Plan.**

Section 4. Other Important Terms You should know

The terms defined in the Base Plan and at other junctures in the Policy Wording have the meanings ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same. All terms are subject to the terms defined in the Base Plan and additional terms defined below.

Def. 1. **Base Plan** means any retail indemnity health Insurance policy issued by HDFC ERGO Health Insurance Limited including its terms and conditions, any annexure thereto and the Policy Schedule (as amended from time to time), the information statements in the proposal form and the Policy wording (including endorsements, if any) and to which this Rider is attached.

Def. 2. **Bank rate** shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def. 3. **Cashless facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

Def. 4. **Commencement Date** means the commencement date of this Policy as specified in the Schedule.

Def. 5. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def. 6. **Multiplier Benefit/Cumulative Bonus** means any increase in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 7. **Day Care centre** means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—
-has qualified nursing staff under its employment;
-has qualified medical practitioner/s in charge;
-has a fully equipped operation theatre of its own where surgical procedures are carried out;
-maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

Def. 8. **Dependents** means only the family members listed below:

i) Your legally married spouse as long as she continues to be married to You;
ii) Your children Aged between 91 days and 25 years if they are unmarried
iii) Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his initial participation in this Policy.

iv) Your Parents -in-law as long as Your spouse continues to be married to You and were below 65 years at his initial participation in this Policy.

All Dependent parents must be financially dependent on You.

Def. 9. **Dependent Child** means a child (natural or legally adopted), who is unmarried, aged between 91 days and 25 years, financially dependent on the primary Insured or Proposer and does not have his / her independent sources of income.

Def. 10. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def. 11. **Family Floater** means a Policy described as such in the Schedule where under You and Your Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during the Policy Period.

Def. 12. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-Existing Diseases. Coverage is not available for the period for which no premium is received.

Def. 13. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- has qualified nursing staff under its employment round the clock,
- has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
- has qualified Medical Practitioner(s) in charge round the clock,
- has a fully equipped operation theatre of its own where surgical procedures are carried out,
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def. 14. **Hospitalisation** or **Hospitalised** means admission in a Hospital for a minimum of 24 consecutive 'in-patient' hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

Def. 15. **Inpatient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

Def. 16. **Insured Person means** You and the persons named in the Schedule.

Def. 17. **Material Facts** means all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

Def. 18. **Network Provider** means Hospitals or health care providers enlisted by an insurer, TPA, or by a TPA and insurer together to provide medical services to an insured by a cashless facility

Def. 19. **Non Network means** any Hospital, day care centre or other provider that is not part of the Network

Def. 20. **Notification of Claim** means the process of notifying a claim to the insurer or TPA through any of the recognized modes of communication.

Def. 21. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 22. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 23. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for **Pre-Existing Diseases**, time-bound exclusions and for all waiting periods.

Def. 24. **TPA** means the third party administrator that We appoint from time to time as specified in the Schedule.

Def. 25. **We/Our/Us** means the HDFC Ergo Health Insurance Company Limited.

Def. 26. **You/Your/Policyholder** means the insured person named in the policy Schedule who is insured under the policy.

Section 5. Claim Procedure

What do I do in case of a claim or any assistance?
Please quote your member ID/policy number in all your correspondences.

Intimation & Assistance	Procedure for Reimbursement of Medical Expenses	Procedure to avail Cashless facility
Please use the Claim Intimation Form (available on our website under Other Forms in the Downloads section) for intimation of a claim **For claims related to Planned Hospitalization:** contact us at least 48 hours prior to hospitalization **For claims related to unplanned or Emergency Hospitalization:** contact us within 24 hours of hospitalization **All the other benefits except Hospitalization**: contact us Within 7 days of the Insured Person's discharge post-hospitalization We can be contacted through: - Website : www.hdfcergohealth.com - Toll Free : 1800-102- 0333 - Fax : 1800- 425- 4077 - Courier :	• Please send the duly signed claim form and all the information/ documents mentioned* therein to us within 15 days of the completion of the treatment * Please refer to claim form for complete documentation • If there is any deficiency in the documents/information submitted by you, We will send the deficiency letter within 7 days of receipt of the claim documents • On receipt of the complete set of claim documents, we will make the payment for the admissible amount, along with a settlement statement within 30 days • The payment will be made in the name of the proposer **Note:**	• For any planned hospitalization, kindly seek cashless authorization from us at least 48 hours prior to the hospitalization • For any emergency Hospitalisation, We must be informed no later than 24 hours after hospitalization • We will check your coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent, the same shall be communicated to the hospital within 6 hours of receipt of documents • In case the ailment /treatment is not covered under the policy a rejection letter would be sent to the provider within 6 hours

Claims Department, HDFC ERGO Health Insurance Limited, Ground floor, Srinilaya – Cyber Spazio Suite # 101,102,109 & 110, Ground Floor, Road No. 2, Banjara Hills, Hyderabad-500 034 Or Claims Department, HDFC ERGO Health Insurance Limited, 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana.	Payment will only be made for items covered under your Base Plan and up to the limits therein.	**Note:** • Insured person is entitled for cashless only in our empaneled hospitals • Please refer to the list of empaneled hospitals on our website Or the list provided in the welcome kit • Rejection of cashless in no way indicates rejection of the claim

For any doubt or clarifications and/or information, call our Toll Free Line at 1800-1020-333 or log on to our website- www.hdfcergohealth.com or email us at customerservice@hdfcergohealth.com

Supporting Documentation & Examination

We may request any document to establish our liability towards a claim within 15 days of either Our request or the Insured Person's discharge from Hospital or completion of treatment, whichever is earlier. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured.

Following is the list of mandatory documents that need to be submitted with every claim:

i) Our claim form, duly completed and signed for on behalf of the Insured Person.
ii) Original Bills (including but not limited to pharmacy purchase bill, consultation bill, and diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.
iii) All reports and records, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.
iv) A precise diagnosis of the treatment for which a claim is made.
v) A detailed list of the individual medical services and treatments provided and a unit price for each (detailed break up).
vi) Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Doctor's invoice.
vii) All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made.
viii) Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements.

Below list of documents but not limited to the following, will have to be submitted on case to case basis:

i) Indoor Case Papers
ii) All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses.
iii) Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident.
iv) Copy of settlement letter from other insurance company or TPA.
v) Stickers and invoice of implants used during surgery.
vi) Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident.
vii) Legal heir certificate.

The Insured Person shall have to undergo medical examination by Our authorized Medical Practitioner, as and when We may reasonably require, to obtain an independent opinion for the purpose of processing any claim. We will bear the cost towards performing such medical examination (at the specified location) of the Insured Person.

Section 6. Grievance Redressal Procedure

In case of any grievance the insured person may contact the company through:

- Our website : www.hdfcergohealth.com
- E-mail : customerservice@hdfcergohealth.com
- E-mail specific for Senior citizens : seniorcitizen@hdfcergohealth.
- Toll Free : 1800-102-0333
- Fax : +91-124-4584111
- Courier : Any of Our Branch office or Corporate office

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:

The Grievance Cell, HDFC ERGO Health Insurance Limited, 2nd and 3rd Floor, iLABS Centre, Plot No 404-405, Udyog Vihar, Phase III, Gurgaon, Haryana-122016.
For updated details of grievance officer, kindly refer the link: https://www.hdfcergohealth.com/escalate-your-case.aspx

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

The contact details of Ombudsman offices are mentioned below.

Office Details	**Jurisdiction of Office Union Territory, District)**
AHMEDABAD - ShriKuldip Singh Office of the Insurance Ombudsman, JeevanPrakash Building, 6th floor, TilakMarg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.

Office Details	**Jurisdiction of Office Union Territory, District)**
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI - ShriSudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI - ShriKiriti .B. Saha Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR - Smt. SandhyaBaliga Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM - Ms. PoonamBodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA - Shri P. K. Rath	West Bengal,

Office Details	**Jurisdiction of Office Union Territory, District)**
Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	Sikkim, Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - ShriMilind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE - ShriVinaySah Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

IRDAI REGULATION NO 12: This Policy is subject to regulation 12 of IRDAI (Protection of Policyholder's Interests) Regulation 2017.

Annexure I – List of excluded items

S. No.	Item	S. No.	Item
1	BABY FOOD	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
2	BABY UTILITIES CHARGES	36	SPACER
3	BEAUTY SERVICES	37	SPIROMETRE
4	BELTS/ BRACES	38	NEBULIZER KIT
5	BUDS	39	STEAM INHALER
6	COLD PACK/HOT PACK	40	ARMSLING
7	CARRY BAGS	41	THERMOMETER
8	EMAIL / INTERNET CHARGES	42	CERVICAL COLLAR
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	43	SPLINT
10	LEGGINGS	44	DIABETIC FOOT WEAR
11	LAUNDRY CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)
12	MINERAL WATER	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
13	SANITARY PAD	47	LUMBO SACRAL BELT
14	TELEPHONE CHARGES	48	NIMBUS BED OR WATER OR AIR BED CHARGES
15	GUEST SERVICES	49	AMBULANCE COLLAR
16	CREPE BANDAGE	50	AMBULANCE EQUIPMENT
17	DIAPER OF ANY TYPE	51	ABDOMINAL BINDER
18	EYELET COLLAR	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
19	SLINGS	53	SUGAR FREE TABLETS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	55	ECG ELECTRODES
22	TELEVISION CHARGES	56	GLOVES
23	SURCHARGES	57	NEBULISATION KIT
24	ATTENDANT CHARGES	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	59	KIDNEY TRAY
26	BIRTH CERTIFICATE	60	MASK
27	CERTIFICATE CHARGES	61	OUNCE GLASS
28	COURIER CHARGES	62	OXYGEN MASK
29	CONVEYANCE CHARGES	63	PELVIC TRACTION BELT
30	MEDICAL CERTIFICATE	64	PAN CAN
31	MEDICAL RECORDS	65	TROLLY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE
34	WALKING AIDS CHARGES	68	VASOFIX SAFETY